Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Consultants in Pain Management

Respondent Name
Amerisure Mutual Insurance

MFDR Tracking Number
M4-15-1304-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
December 29, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…Amerisure did not apply the Title 28 Texas Administrative Code Rule 134.203 (b) for medical fee guidelines, and 134.600 preauthorization guidelines when auditing our billed laboratory services."

Amount in Dispute: $94.78

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "G0431 Drug screen was denied per ODG guidelines utilizing billed ICD9 Code 924.2."

Response Submitted by: Amerisure, 5221 North O-Connor Boulevard, Suite 400, Irving, TX 75039-3711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 27, 2014	G0431	$94.78	$94.78

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out guidelines for prospective and concurrent review of health care services.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197 – Payment denied/reduced for absence of precertification/preauthorization

Issues

1. Was prior authorization required?

2. What is the applicable rule pertaining to reimbursement?
3. Is the requestor entitled to reimbursement?

Findings

1. The Carrier in their response to MFDR stated, "G0431 Drug screen was denied per ODG guidelines utilizing billed ICD 9 Code 924.2…"

   Review of the submitted medical claim finds;

   a. Submitted ICD9 code 724.2 (not 924.2 as submitted by the Carrier)

   Review of the 2014 ODG ICD9-CPT Crosswalk, UR Advisor for submitted code 724.2 finds nothing to support the Carrier's denial..
2. 28 Texas Administrative Code §134.600 (p) states in pertinent part, "Non-emergency health care requiring preauthorization includes: …" Clinical laboratory services are not listed as a service that requires prior authorization, the Carrier's denial is not supported. Therefore, the services in dispute will be reviewed per applicable rules and fee guidelines.
3. 28 Texas Administrative Code §134.203 (e) states in pertinent part, "The MAR for pathology and laboratory services not addressed in subsection (c)(1) of this section or in other Division rules shall be determined as follows: (1) 125 percent of the fee listed for the code in the Medicare Clinical Fee Schedule for the technical component of the service;" The maximum allowable reimbursement will be calculated as follows;

   a. 2014 Clinical Diagnostic Laboratory Fee Schedule Allowable for Texas $75.82 x 125% = $94.78

   The maximum allowable reimbursement is $94.78. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $94.78.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $94.78 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 29, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.